Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
TITUS COUNTY MEMORIAL HOSPITAL
2001 N JEFFERSON AVE
MT PLEASANT TX 75455-2336

Respondent Name
TASB RISK MGMT FUND

Carrier's Austin Representative Box
47

MFDR Tracking Number
M4-98-4426-01

MFDR Date Received
September 2, 1997

REQUESTOR'S POSITION SUMMARY

Requestor's Documentation: None found/provided

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None found/provided

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 1996 to December 7, 1996	Inpatient Hospital Services	$2,372.36	$0.00

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §102.5, adopted to be effective July 29, 1991, 16 *Texas Register* 3939; amended to be effective March 15, 1995, 20 *Texas Register* 1418, sets out the guidelines for written communications from the Division, formerly the Commission.
3. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, effective December 31, 2006, section (f) sets out the procedures for parties seeking review of a medical fee dispute decision or dismissal.

4. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied).

Finding

Existing records indicate that the Medical Fee Dispute Resolution (formerly medical review) program docketed a request for medical fee dispute resolution as described in the *General Information* section above. On May 29, 2012, the parties in dispute were notified that the division was unable to locate the physical documentation associated with the aforementioned dispute. This notice was made in the form of a letter which was sent to:

(1) the requestor via regular mail to the address listed above;
(2) the Texas Hospital Association, Attention Charles Bailey, via USPS certified mail tracking number 91710821333938218995 51, to 1108 Lavaca Ste 700, Austin, Tx 78701-2172; and
(3) the respondent via its Austin representative box as listed above.

The division, as required by 28 TAC §102.5 (e) effective for the dates of service in dispute, relied upon information supplied by the requestor or health care provider, and all its known representatives for delivery of the letter. Similarly, the division relied upon the information supplied by the respondent for delivery of the letter to its appropriate Austin carrier representative as required in 28 TAC §102.5 (b). Charles Bailey, General Counsel of the Texas Hospital Association was notified pursuant to his March 15, 2006 deposition in *HCA Healthcare Corp. v. Tex. Dep't. of Ins*., 303 S.W.3d 345 (Tex. App. - Austin, 2009, no pet) in which Mr. Bailey specified that the Texas Hospital Association would cooperate with the division in seeing that dispute decisions over former, invalidated, 28 Texas Administrative Code §134.400, 17 *TexReg* 4949 titled *Acute Care Inpatient Hospital Fee Guideline* would be sent to the proper and correct addresses of the claimant hospitals.

The letter to the parties included a request for copies of: (1) the original request for dispute resolution; (2) additional information; (3) copies of correspondence; and (4) any additional documentation or information the parties saw fit to provide. Additionally, the party proving documentation was instructed forward a copy to all other parties at the time it was provided to the division. To date, the division has no record of receiving any responsive documentation from the respondent, requestor, nor from any representatives of the requestor

28 Texas Administrative Code §133.305, effective June 3, 1991, states, in pertinent part, "(k) The division of medical review shall proceed with the review of the medical dispute after all required and requested information has been received." No documentation was provided by the requestor upon the division's request; consequently, the division finds that the requestor has failed to support its request for additional reimbursement.

Conclusion

The division concludes that the requestor has not supported its request for additional reimbursement. For that reason, no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/12/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.